Atrium Health Infusion Centers
Phone: 704-468-3400 **Fax:** 704-468-3401

Rapid Rituxan Infusion Order (Revised 9/7/21)

Instructions to Provider: All orders with ☒ will be placed unless otherwise noted. Please fax completed order, along with referral form.

Required Lab Results: CBC with diff within 90 days of Day 1 infusion (If outside of Atrium, please fax with order. Required prior to scheduling.)

Infusion Therapy:

☐ Rituxan (rituximab) _____mg x2 doses (Day 1 and Day 15) every **_____**months

☐ Rituxan (rituximab) _____ mg x 1 dose **Frequency: _____**

Pre-Meds: **ICD 10 code: _____**

Administer 30 minutes prior to Rituxan

☒ Acetaminophen **_____** mg PO x 1 ☒ SoluMedrol **_125__** mg IV x 1

☒ Benadryl **_____** mg PO or **_____** mg IV x 1 *(if applicable, only choose ONE)*

PRN Medications:

☒ Acetaminophen **500mg** PO every 4 hours PRN pain (give first)

☒ Ibuprofen **800mg** PO x 1 PRN pain (give second)

☒ Zofran **4mg** IV every 3 hours PRN nausea/vomiting

Additional Orders:

_____

Special Instructions:

- **Fluid/Volume: Normal Saline 0.9% for 1:1 concentration for Initial/Subsequent Rates**
- **Initial infusion rates:** 50mg/hour x30 minutes. If tolerated increase the rate by 50 mg/hour every 30 minutes as tolerated to a max rate of 400mg/hour.
- **For subsequent infusions:** start at 100mg/hour for 30 minutes. If patient tolerates the infusion, increase the rate by 100mg/hour every 30 minutes as tolerated to a max rate of 400mg/hour.
- **Rapid Rate Rituxan:** Infuse over 90 minutes with first 20% of the dose administered over 30 minutes and the remaining 80% administered over the remaining 60 minutes. **(*Total volume: 500mL*).** May increase to rapid rate following 2 subsequent infusions without infusion reactions.
- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.

Infusion Monitoring:

- Obtain vital signs pre- and post-infusion. Obtain vital signs 30 mins after initiation of infusion then PRN during infusion.
- Monitor for 30 mins after infusion PRN if signs of reaction observed.

Provider Name: _____
Provider Signature: _____
Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN: